Office of the
TREASURER

TELEPHONE: (508) 841-8359
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benefits@shrewsburyma.gov

TOWN OF SHREWSBURY

Richard D. Carney Municipal Office Building
100 Maple Avenue
Shrewsbury, Massachusetts 01545-5338

2020 - 2021

Welcome New Employee.

Congratulations on your employment with The Town of Shrewsbury. The following are some of the benefits available to you.

Health Insurance, Flexible Spending Accounts, Health Savings Accounts, Life Insurance and Altus Dental benefits are offered to employees hired for a permanent position that work 20 or more regular hours a week. Coverage is effective as of date of hire.

Health Insurance - You must enroll within 30 days of your hire date or you will be required to wait until Open Enrollment or when you experience a qualifying event. To enroll, you must complete an insurance application, a Payroll Authorization Agreement, and provide a copy of your Social Security card. For a Family plan, please also provide a copy of the city/town issued Marriage Certificate/Divorce Decree to enroll a current or ex-spouse and copy of the Birth/Adoption Certificate or Court Order to enroll each child. Copies of Social Security cards are required to enroll any and all dependents.

Plan details and applications are available on the Town's website, https://shrewsburyma.gov. Click on Government and under Town Departments click on Treasurer.

The following plans are available:

- Harvard Pilgrim PPO
- Harvard Pilgrim Benchmark HMO
- Harvard Pilgrim High Deductible
- Tufts Benchmark HMO
- Tufts High Deductible
- BCBS Benchmark HMO
- BCBS High Deductible
- Fallon Select Care Benchmark HMO
- Fallon Select Care High Deductible
- Fallon Direct Care Benchmark HMO
- Fallon Direct Care High Deductible

Documents attached

- Health Insurance Rate Sheet
- Plan Comparison Chart
- Payroll Authorization Agreement
- Health Insurance Enrollment Forms
- *Information about Qualifying Events
- Notice- Enrollment of Adult Children
- Initial COBRA Rights Notice
- Health Insurance Marketplace Notice
- HIPAA Notice of Privacy Practices
- Medicaid/CHIP Notice
- Miscellaneous Legal Notices
- Medicare Eligibility Information
- Medicare Part D Creditable Coverage Notice

1. **Flexible Spending Accounts for Medical/Dental Care (up to $2,750) and Dependent Care (up to $5,000)** allow you to set aside a portion of your paycheck on a pre-tax basis. They are offered during an Open Enrollment period in April with a July 1st effective date. A change in status during the year allows you to enroll outside of the Open Enrollment window. The following are qualifying events for enrollment in these plans: New Hire, Marriage, Divorce, Birth, Adoption, and a Return from LOA. The effective date is the date of the event. You must enroll within 30 days of the qualifying event or you will be required to wait until Open Enrollment. To enroll, please contact Cafeteria Plan Advisors at 781-848-9848.
2. **Health Savings Accounts** - are available to those enrolled in a High Deductible Health Plan. This plan allows you to make tax-free contributions to an FDIC-insured savings account. Attached is a brochure and enrollment form. Please contact Health Equity directly with any questions at 1-866-346-5800.

HIPAA Special Enrollment Notice

If you are declining enrollment either for yourself or for your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents **lose eligibility** for that other coverage (or if the employer stops contributing toward your coverage or your dependents' coverage). However, you must request enrollment within **30 days** after the date your coverage, or your dependents' coverage, ends (or after the employer stops contributing toward the other coverage).*

In addition, if you have a new dependent as a result of **marriage, birth, adoption,** or **placement for adoption**, you may be able to enroll yourself and your dependents. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage and you request enrollment within **60 days** after that coverage ends; or

- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within **60 days** after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

To request special enrollment or obtain more information, contact Donna Bouchard, Benefit Administrator, at benefits@shrewsburyma.gov or 508-841-8539.

***Documentation is required for each life event within 30 days from the life event.**

Newborns Act Notice

Group Health Plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

3. **Life Insurance** – Three plans offered through Boston Mutual Life Insurance. You must enroll within 30 days of your hire date. To enroll at a later date you will be subject to medical underwriting.
   - **Basic Term Life Insurance** - a $7,000 term life policy with a $7,000 AD&D benefit.
   - **Optional Term Life Insurance** for the employee, spouse and dependent children. There are no dividends or cash value.
     Employee: increments of $10,000 to $500,000, not to exceed 7 times base pay. Guaranteed issue is $150,000.
     Spouse: increments of $10,000 to $150,000, not to exceed employee's amount. Guaranteed issue is $30,000.
     Dependent: $10,000 for unmarried children to age 19, or up to 25 if full-time students.
   - **Voluntary Supplemental Insurance** – A Whole Life policy with guaranteed issue, without medical at initial eligibility. Face value is based on the subscriber's age and amount of weekly contribution (with a maximum contribution of $12.00 per week). Please call Life Plus Insurance Agency at 781-837-9222 for more information and to enroll.

   Documents attached:
   - FAQ for Basic and Optional Life Insurance
   - Rate Sheet Optional Life Insurance
   - Application for Basic and Optional Life Insurance

4. **Altus Dental** – Town Employees - Contact Benefits Administrator, Donna Bouchard for enrollment
   School Employees – Contact School Payroll department for enrollment

5. **Insurance Declination Form** - must be completed by newly benefit eligible employees **who are not** enrolling in Health, Life or Town Dental insurance.

6. **Deferred Compensation- Life Annuity Plans-ROTH** If interested, contact:
   - **Commonwealth of Massachusetts 457 Deferred Compensation SMART Plan**
     Eileen Neubert, SMART Plan Representative, Tel: (877) 457-1900, say representative, 4 times, then enter (extension) 20083 - Email: Eileen.Neubert@empower-retirement.com
   - **Pacific Life Insurance Company - 457 Deferred Compensation Plan**
     Michael Farmer, Financial Planner, Tel: (508) 926-1452 - Email: mike.farmer@ifpadvisor.com
   - **ICMA-RC – 457 Deferred Compensation Plan / ROTH**
     Michael Savage, Certified Retirement Counselor, Tel: (888) 803-2721 msavage@icmarc.org

7. **The Town of Shrewsbury Wellness Program** funds initiatives that focus on improving our health in ways that aren't covered through insurance. These programs include yoga classes, coordinated by the Parks and Recreation department, and other programs through the West Suburban Health Group including but not limited to the following:

   My Medication Advisor - a web-based program that includes the opportunity for filling 3 months of maintenance medications at a time through vendors from Canada, England, New Zealand and Australia with a $0 co-pay.
   Good Health Gateway - a diabetes care rewards program for those insured through a Town health plan as a subscriber or dependent. You can be eligible for free diabetic medications and supplies by following five care guidelines.
   Fitness Reimbursements for members our Health Plans. The benefit varies by carrier.

   For more information go to *http://westsuburbanhealth.com/wellness/*.

8. **MetLife Auto & Home** offers Town of Shrewsbury employees special group discounts on auto insurance. Contact Lisa Souza at 781-749-2007, or Lsouza@metlife.com for more information.

Your payroll clerk will inform you of other available benefits based on your department and position.

Best Wishes,
Donna Bouchard
Benefits Administrator

Office of the
TREASURER

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Availability of Summaries of Benefits and Coverage

The health insurance benefits available to you as an employee represents a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

You have the choice of several different plans. Selecting a health insurance plan is an important decision. To help you make an informed choice the plans offered by the Town provide a Summary of Benefits and Coverage (SBC). These SBCs summarize key plan features in a standard format to help you compare your options.

The SBCs are available on the Town of Shrewsbury's website. From the home page select the Treasurer's Department, then Health Insurance, then Summaries of Benefits and Coverage.

New Hire Benefits Paperwork Checklist

If enrolling in:

Health Insurance

- ☐ Employee Payroll Agreement
- ☐ Health Insurance Application (Fallon, BCBS, Harvard Pilgrim or Tufts)*
  - ☐ Social Security Cards – of employee, spouse and child(ren) you are enrolling
  - ☐ City/Town Issued Marriage License or Divorce Decree (if enrolling a spouse or ex-spouse)**
  - ☐ Children 's Birth Certificates, Adoption Forms or Guardianship Papers (if enrolling child(ren))
  - ☐ HSA deduction form (if enrolling in a High Deductible Plan)

Life Insurance

- ☐ Boston Mutual Enrollment Application (beneficiary info)

Dental Insurance (TOWN employees only)

- ☐ Insurance Application

Flexible Spending Account(s)

Contact Cafeteria Plan Advisors directly for enrollment: 781-848-9848

If declining Health, Dental and/or Life Insurance:

- ☐ Declination of Insurance Form

TOWN OF SHREWSBURY
DECLINATION OF INSURANCE

EMPLOYEE NAME _____

SOCIAL SEC. # _____

DEPARTMENT _____

I have been offered the opportunity to participate in the insurance benefit plans made available through the Town of Shrewsbury. These plans have been explained to me and I wish not to enroll in the following plans at this time:

( ) **Health Insurance**
I understand that I have the opportunity to enroll in Health Insurance at Open Enrollment each year (effective July 1st) or with a Qualifying Event off anniversary

( ) **Altus Dental Insurance (Town employees only)**

( ) **Basic Life Insurance** $7,000 & $7,000 AD&D
( ) **Optional Life Insurance** Face value premium based on age bracket
( ) **Whole Life Insurance** Face value based on age & weekly premium

I understand that I must prove my insurability for Life Insurance if I want to be covered at a later date by completing an Evidence of Insurability application and possibly a physical exam at my expense.

_____ _____
Employee's Signature Date

TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP ACTIVE PLANS 2020-2021
JUNE PAYROLL CHANGES FOR JULY 1, 2020 OPEN-ENROLLMENT

% PAID TOWN/EMP	PLAN TYPE	TOTAL MONTHLY		TOWN MONTHLY	TOWN 26 P/R BI-WEEKLY	TOWN 21 P/R BI-WEEKLY*		EMPLOYEE MONTHLY	EMP. 26 P/R BI-WEEKLY	EMP. 21P/R BI-WEEKLY*		COBRA
BENCHMARK HMO PLANS												
BLUE CROSS NETWORK BLUE BENCHMARK												
60/40	**FAMILY**	***$2,863.00***		$1,717.80	$792.83	$981.60		**$1,145.20**	**$528.55**	**$654.40**		$2,920.26
50/50	FAMILY (SS)	***$2,863.00***		$1,431.50	$660.69	$818.00		$1,431.50	$660.69	$818.00		
60/40	**INDIVIDUAL**	***$1,068.00***		$640.80	$295.75	$366.17		**$427.20**	**$197.17**	**$244.11**		
50/50	INDIVIDUAL (SS)	***$1,068.00***		$534.00	$246.46	$305.14		$534.00	$246.46	$305.14		$1,089.36
TUFTS BENCHMARK												
60/40	**FAMILY**	***$2,838.00***		$1,702.80	$785.91	$973.03		**$1,135.20**	**$523.94**	**$648.69**		$2,894.76
50/50	FAMILY (SS)	***$2,838.00***		$1,419.00	$654.92	$810.86		$1,419.00	$654.92	$810.86		
60/40	**INDIVIDUAL**	***$1,084.00***		$650.40	$300.18	$371.66		**$433.60**	**$200.12**	**$247.77**		$1,105.68
50/50	INDIVIDUAL (SS)	***$1,084.00***		$542.00	$250.15	$309.71		$542.00	$250.15	$309.71		
HPHC BENCHMARK												
60/40	**FAMILY**	***$2,683.00***		$1,609.80	$742.98	$919.89		**$1,073.20**	**$495.32**	**$613.26**		$2,736.66
50/50	FAMILY (SS)	***$2,683.00***		$1,341.50	$619.15	$766.57		$1,341.50	$619.15	$766.57		
60/40	**INDIVIDUAL**	***$1,030.00***		$618.00	$285.23	$353.14		**$412.00**	**$190.15**	**$235.43**		$1,050.60
50/50	INDIVIDUAL (SS)	***$1,030.00***		$515.00	$237.69	$294.29		$515.00	$237.69	$294.29		
FALLON SELECT BENCHMARK												
73/27	**FAMILY**	***$2,129.00***		$1,554.17	$717.31	$888.10		**$574.83**	**$265.31**	**$328.47**		$2,171.58
50/50	FAMILY (SS)	***$2,129.00***		$1,064.50	$491.31	$608.29		$1,064.50	$491.31	$608.29		
73/27	**INDIVIDUAL**	***$790.00***		$576.70	$266.17	$329.54		**$213.30**	**$98.45**	**$121.89**		$805.80
50/50	INDIVIDUAL (SS)	***$790.00***		$395.00	$182.31	$225.71		$395.00	$182.31	$225.71		
FALLON DIRECT BENCHMARK												
78/22	**FAMILY**	***$1,980.00***		$1,544.40	$712.80	$882.51		**$435.60**	**$201.05**	**$248.91**		$2,019.60
50/50	FAMILY (SS)	***$1,980.00***		$990.00	$456.92	$565.71		$990.00	$456.92	$565.71		
78/22	**INDIVIDUAL**	***$736.00***		$574.08	$264.96	$328.05		**$161.92**	**$74.73**	**$92.53**		$750.72
50/50	INDIVIDUAL (SS)	***$736.00***		$368.00	$169.85	$210.29		$368.00	$169.85	$210.29		

(SS) REPRESENTS SURVIVING SPOUSE

SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)

WEST SUBURBAN HEALTH GROUP

IMPORTANT - PLEASE READ

The attached benefit comparison chart is a high level overview of the plans offered by WSHG.

The plan documents available to registered users on the carrier websites are the documents that describe full and complete plan details.

The carrier documents are the only documents that coverage is based on.

Should you have a question about specific coverage, you will need to contact the Member Service number on your ID card for detail or visit the carrier website.

WEST SUBURBAN HEALTH GROUP

Effective 07-01-2020

BENCHMARK HEALTH PLAN COMPARISON CHART July 1, 2020

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None
Deductible - applies to: In-patient Admission; Out-patient Surgery; ER, High Tech Imaging (MRI, CT, & PET) and Diagnostic Tests & Procedures. Does not apply to office visits or pharmacy. Per plan year (July 1 to June 30) - *See plan document for full details*	IND $300 FAM $900	IND $300 FAM $900	IND $300 FAM $900	IND $300 FAM $900
Out-of-Pocket (OOP) Maximum - Once your out-of-pocket expenses for applicable services reaches this amount, you pay $0 for remainder of plan year. Effective July 1, 2015, out-of-pocket maximums for prescription copays have been added as required by ACA (in-network only).	**Medical -** $2,000 per member $4,000 per family per plan year **Prescription-** $2,000 per member $4,000 per family per plan year see plan for details	**Medical -** $2,000 per member $4,000 per family per plan year **Prescription-** $2,000 per member $4,000 per family per plan year see plan for details	**Medical -** $2,000 per member $4,000 per family per plan year **Prescription-** $2,000 per member $4,000 per family per plan year see plan for details	**Medical & Prescription Combined -** $2,000 Individual per plan year $4,000 Family per plan year
Family Covered	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Member must select	Member must select	No selection required	Member must select
Specialist Referrals	PCP must refer	PCP must refer	No referral required	PCP must refer
Providers of Service	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities throughtout Massachusetts, southern New Hampshire and southwestern Vermont. ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions
INPATIENT				
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Deductible applies then: Tier 1 : $250 Tier 2 :$500 Tier 3 : $1500 per/Admit NOTE-Mental Health/Substance Abuse copay $250	Deductible , then Tier 1: $500 copay Tier 2: 1500 copay	Semi-private room & board & ancillary services Tier 1: $500 copay, then deductible applies Tier 2: $1500 copay, then deductible applies NOTE-Mental Health/Substance Abuse	$500 copay per admission, then deductible No co-pay or deductible for Mental Hospital/Substance Abuse Facility

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Physician Services	Nothing	Nothing	Nothing	Nothing, after deductible
Skilled Nursing Facility	Deductible applies, then 20% Coinsurance - Limited to 100 days per Plan Year	Deductible, then covered in full	Covered in Full after Deductible, up to 100 days per plan year	$500 copay per admission, then deductible Max of 100 days per year.
Newborn Well Baby Care (Inpatient)	Nothing	Nothing	Nothing	Nothing
OUTPATIENT				
Emergency Room Visits for Emergency or Accident Care	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	Deductible applies, then $100 Copay per visit. Copay is waived if admitted to the hospital directly from the emergency room, then Inpatient copay would apply	$100 copay, then deductible applies (Inpatient copay applies if admitted)	$100 copay, then deductible applies (waived if admitted, then Inpatient copay applies)
Outpatient Surgery in a Day Surgery facility or Hospital	Deductible applies, then $250 copay per visit	Deductible applies, then $250 copay per visit	$250 copay per outpatient surgery, then deductible	$250 copay per outpatient surgery, then deductible
CT, MRI and Pet Scans	Deductible applies, then $100 Copay per procedure	Deductible, then $100 copay (scheduled outpatient)	$100 copay, then Deductible	$100 copay, then deductible
Hemodialysis	Non - hospital based - Deductible applies, then no charge Hospital based - See Inpatient	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Physical Therapy	Copay: $20 per visit - Limited to 30 visits per plan year	$20 copay; up to 60 visits per calendar year (Unlimited for autism)	Speech and short-term PT/OT $20 copay per visit; 30 visits per plan year	$20 copay. PT / OT Max limit up to 60 visits per plan year
Office Visits Primary Care Physician	$20 copay per visit	$20 copay	$20 copay per visit	$20 copay per visit
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care *(Mental Health copays excluded from OOP max)*	$20 copay per visit	$20 per visit	$20 copay per visit	$20 copay per visit
Office Visits Specialist	Tier 1 : $30 copay per visit Tier 2: $60 copay per visit Tier 3: $90 copay per visit	$60 copay per visit	$60 copay per visit	$60 copay per visit
OB/GYN	$20 copay per visit	$20 copay per visit	$20 copay per visit	$20 copay per visit
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Routine Vision Exam	$0 copay - 1 every 2 years	$0 copay; one visit every 12 months	$20 copay per visit; one visit per plan year Eyewear discounts available at participating providers	$0 copay per visit; one visit every 12 months Eyewear discounts available at participating EYEMed providers
Pre-Admission Testing -	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Nothing	Nothing	Nothing for prenatal and postnatal outpatient care	Prenatal: $20 copay first visit only; Postnatal: $20 copay per visit

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Dental Services	**Children up to age 13** - Preventative dental when authorized by PCP; up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	**Children under age 12**: Preventive dental one exam every six months., incl. Cleaning, fluoride treatment and x-rays. **All members**: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed.	**Children under age 12**; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	**Family dental coverage:** $10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.
OTHER FEATURES				
Private Duty Nursing (only when medically necessary)	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary	Nothing when medically necessary
Home Health Care	Member cost sharing depends on types of services provided and tier placement of provider rendering devices, as listed in the Schedule of Benefits. For example, for services provided by a physician, see "physician and Other Professional Office Visits." For inpatient hospital care, see "Hospital - Inpatient Services."	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Hospice Care	Same as Home Health Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Durable Medical Equipment	Deductible, then CIF^	Deductible, then 20% coinsurance	Covered in Full	Deductible, then CIF^ 20% coinsurance after the deductible for prosthetic limbs which replace, in whole or in part, an arm or leg.
Ambulance	Nothing when medically necessary	Deductible then covered in full	Covered in full when medically necessary	Covered in full when medically necessary
Radiation Therapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chemotherapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chiropractor Visits	$20 copay, 20 visits per plan year	$20 copay per visit. 12 visits maximum per calendar year	$20 copay per visit; up to 12 visits per plan year	$20 copay per visit; up to 12 visits per plan year.
Prescription Drugs (Inpatient drugs paid in full)	**Retail Pharmacy:** Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail Pharmacy:** Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail Pharmacy:** Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay	**Retail Pharmacy:** Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply)** Tier 1: $25.00 copay Tier 2: $75.00 copay Tier 3: $165.00 copay

	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
PLAN TYPE	BENCHMARK	BENCHMARK	BENCHMARK	BENCHMARK
^ CIF = Covered in Full	CHOICENET	NETWORK BLUE NE		
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Fitness Benefit	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**
	Fitness reimb up to **$150** per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.	Up to $300 reimbursement toward health club membership or exercise classes. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details.	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for individual contracts)and Direct Care members up to **$500** per family contract (**$250** for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment.
	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.

* **Fallon DirectCare** - Members now have access to Acton Medical Associates, Charles River Medical Associates and Southboro Medical Group, Fallon Clinic, Highland Healthcare Associates IPA, Lahey Clinic, Lawrence General IPA, Lowell General PHO, Mount Auburn Cambridge IPA, and Northeast PHO.

****FCHP SelectCare** - Members have access to FCHP Clinic providers, as well as hundreds of private practice physicians in Central, Northern, Eastern and Southeastern, Massachusetts.

TOWN OF SHREWSBURY
WEST SUBURBAN HEALTH GROUP ACTIVE PLANS 2020-2021

JUNE PAYROLL CHANGES FOR JULY 1, 2020 OPEN-ENROLLMENT

% PAID TOWN/EMP	PLAN TYPE	TOTAL MONTHLY		TOWN MONTHLY	TOWN 26 P/R BI-WEEKLY	TOWN 21 P/R BI-WEEKLY*		EMPLOYEE MONTHLY	EMP. 26 P/R BI-WEEKLY	EMP. 21P/R BI-WEEKLY*		COBRA
INDEMNITY PLAN												
Harvard Pilgrim PPO												
50/50	**FAMILY**	***$5,902.00***		$2,951.00	$1,362.00	$1,686.29		**$2,951.00**	**$1,362.00**	**$1,686.29**		$6,020.04
50/50	FAMILY (SS)	***$5,902.00***		$2,951.00	$1,362.00	$1,686.29		$2,951.00	$1,362.00	$1,686.29		
50/50	**INDIVIDUAL**	***$2,658.00***		$1,329.00	$613.38	$759.43		**$1,329.00**	**$613.38**	**$759.43**		$2,711.16
50/50	INDIVIDUAL (SS)	***$2,658.00***		$1,329.00	$613.38	$759.43		$1,329.00	$613.38	$759.43		
HIGH DEDUCTIBLE HEALTH PLANS WITH HEALTH SAVINGS ACCOUNTS (HSA)												
BLUE CROSS HSA QUALIFIED PLAN												
60/40	**FAMILY**	***$2,315.00***		$1,389.00	$641.08	$793.71		**$926.00**	**$427.38**	**$529.14**		$2,361.30
50/50	FAMILY (SS)	***$2,315.00***		$1,157.50	$534.23	$661.43		$1,157.50	$534.23	$661.43		
60/40	**INDIVIDUAL**	***$862.00***		$517.20	$238.71	$295.54		**$344.80**	**$159.14**	**$197.03**		$879.24
50/50	INDIVIDUAL (SS)	***$862.00***		$431.00	$198.92	$246.29		$431.00	$198.92	$246.29		
TUFTS HSA QUALIFIED PLAN												
60/40	**FAMILY**	***$2,198.00***		$1,318.80	$608.68	$753.60		**$879.20**	**$405.78**	**$502.40**		$2,241.96
50/50	FAMILY (SS)	***$2,198.00***		$1,099.00	$507.23	$628.00		$1,099.00	$507.23	$628.00		
60/40	**INDIVIDUAL**	***$839.00***		$503.40	$232.34	$287.66		**$335.60**	**$154.89**	**$191.77**		$855.78
50/50	INDIVIDUAL (SS)	***$839.00***		$419.50	$193.62	$239.71		$419.50	$193.62	$239.71		
HPHC HSA QUALIFIED PLAN												
60/40	**FAMILY**	***$2,080.00***		$1,248.00	$576.00	$713.14		**$832.00**	**$384.00**	**$475.43**		$2,121.60
50/50	FAMILY (SS)	***$2,080.00***		$1,040.00	$480.00	$594.29		$1,040.00	$480.00	$594.29		
60/40	**INDIVIDUAL**	***$797.00***		$478.20	$220.71	$273.26		**$318.80**	**$147.14**	**$182.17**		$812.94
50/50	INDIVIDUAL (SS)	***$797.00***		$398.50	$183.92	$227.71		$398.50	$183.92	$227.71		
FALLON SELECT HSA QUALIFIED PLAN												
73/27	**FAMILY**	***$1,795.00***		$1,310.35	$604.78	$748.77		**$484.65**	**$223.68**	**$276.94**		$1,830.90
50/50	FAMILY (SS)	***$1,795.00***		$897.50	$414.23	$512.86		$897.50	$414.23	$512.86		
73/27	**INDIVIDUAL**	***$665.00***		$485.45	$224.05	$277.40		**$179.55**	**$82.87**	**$102.60**		$678.30
50/50	INDIVIDUAL (SS)	***$665.00***		$332.50	$153.46	$190.00		$332.50	$153.46	$190.00		
FALLON DIRECT HSA QUALIFIED PLAN												
78/22	**FAMILY**	***$1,671.00***		$1,303.38	$601.56	$744.79		**$367.62**	**$169.67**	**$210.07**		$1,704.42
50/50	FAMILY (SS)	***$1,671.00***		$835.50	$385.62	$477.43		$835.50	$385.62	$477.43		
78/22	**INDIVIDUAL**	***$620.00***		$483.60	$223.20	$276.34		**$136.40**	**$62.95**	**$77.94**		$632.40
50/50	INDIVIDUAL (SS)	***$620.00***		$310.00	$143.08	$177.14		$310.00	$143.08	$177.14		

(SS) REPRESENTS SURVIVING SPOUSE

SCHOOL EMPLOYEES PAID ON 21 BI-WEEKLY P/R (5 BI-WEEKLY SUMMER DEDUCTIONS ARE INCLUDED IN THE RATES)

WEST SUBURBAN HEALTH GROUP

Effective 07-01-2020

HSA Qualified - HDHP HEALTH PLAN COMPARISON CHART July 1, 2020

red font indicates change or clarification PLAN TYPE	HARVARD PILGRIM HEALTH PLAN	BLUE CROSS BLUE SHIELD	TUFTS HEALTH PLAN	FALLON COMMUNITY HEALTH PLAN
^ CIF = Covered in Full	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP	HSA ELIGIBLE HDHP
BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Lifetime Benefit Maximum	None	None	None	None
Deductible - Once deductible is satisfied, all services CIF^ as noted, with the exception of Prescription Copays	IND $2,000 FAM $4,000 (Non-embedded, plan year deductible, family plan deductible needs to be satisfied before insurance plan kicks in)	IND $2,000 FAM $4,000	IND $2,000 FAM $4,000	IND $2,000 FAM $4,000
Out-of-Pocket (OOP) Maximum-	**Medical & RX COMBINED -** $5,000 per member $10,000 per family per plan year see plan for details	**Medical & RX COMBINED -** $5,000 per member $10,000 per family per plan year see plan for details	**Medical & RX COMBINED -** $5,000 per member $10,000 per family per plan year see plan for details	**Medical & RX COMBINED -** $5,000 per member $10,000 per family per plan year see plan for details
Family Covered	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26	Spouse; dependents; and adult children up to age 26
Selection of Primary Care Physician (PCP)	Member must select	Member must select	Member must select	Member must select
Specialist Referrals	PCP must refer	No referral required	PCP must refer	PCP must refer
Providers of Service	**HARVARD PILGRIM** providers except in emergencies	**HMO BLUE** providers in all 6 New England states except in emergencies	**TUFTS HEALTH PLAN** providers except in emergencies	****SELECT CARE** - An expansive network that includes physician practices, community-based hospitals and medical facilities throughtout Massachusetts, southern New Hampshire and southwestern Vermont. ***DIRECTCARE** - A tailored network custom-built around several of the Commonwealth's premier provider groups and community-based hospitals.
Pre-existing Conditions	No restrictions	No restrictions	No restrictions	No restrictions
INPATIENT				
General Hospital/Mental Hospital/Substance Abuse Facility (semi-private room and board and ancillary services)	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Physician Services	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Skilled Nursing Facility	Deductible, then CIF^ up to 100 days per plan year	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Newborn Well Baby Care (Inpatient)	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
OUTPATIENT				
Emergency Room Visits for Emergency or Accident Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Outpatient Surgery in a Day Surgery facility or Hospital	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
CT, MRI and Pet Scans	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Hemodialysis	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Physical Therapy	Deductible, then CIF^ Limited to 30 visits per plan year	Deductible, then CIF^ Limited to 60 visits per member per calendar year for physical and occupational therapy (unlimited for autism)	Deductible, then CIF^	Deductible, then CIF^ Limited to 60 visits per plan year

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PLAN TYPE				
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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
Office Visits Primary Care Physician	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Preventive OV - PCP	Nothing	Nothing	Nothing	Nothing
Medical Care/Mental Health Care/Substance Abuse Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Office Visits Specialist	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
OB/GYN	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
GYN-Preventive Office visit	Nothing	Nothing	Nothing	Nothing
Diagnostic X-ray and Lab	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Routine Vision Exam	Deductible, then CIF^	Nothing. Covered once every 12 months.	Covered in full	Deductible, then CIF^ Covered in full - one visit every 12 month period Eyewear discounts available at participating EYEMed providers
Pre-Admission Testing -	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Maternity Care visits	Routine OPD, Pre and Post Natal CIF^	Nothing for prenatal; all other serviceds Deductible, then CIF*	Nothing for prenatal and postnatal outpatient care	Prenatal: Nothing Postnatal: Deducible then CIF^
Dental Services	**Deductible, then up to age 13 -** Preventative dental when authorized by PCP; up to two exams per calendar year, including cleaning, fluoride treatment and x-rays. Initial emergency treatment (within 72 hours of injury) necessary to repair oral injuries. Extraction of impacted teeth.	**Children under age 12**: Preventive dental one visit every 6 months., incl. Cleaning, fluoride treatment and x-rays. **All members**: Extraction of impacted teeth imbedded in the bone. Facility charges ONLY when a serious medical condition that requires admittance to a network hospital as inpatient in order for dental care to be safely performed. See Outpatient Surgery for benefit information.	**Children under age 12**; Preventative dental, periodic oral exam, cleaning, fluoride treatment once every six months. X-rays: Full mouth once every five years, bitewing x-rays once every six months, and periapicals as needed. MUST use participating dentist. Emergency Services - LIMITED TO X RAYS AND EMERGENCY ORAL SURGERY ER or OFFICE VISIT COPAY WILL APPLY	**Family dental coverage:** All services subject to the deductible and then the following cost share: $10 copay for exam, cleaning, x-rays every 6 months. Variable copays for minor restorative (fillings). 25 - 50% discount available for sealants, crowns and inlays, bridges, root canals, gingivectomies and dentures. Must use participating dentists.
OTHER FEATURES				
Private Duty Nursing (only when medically necessary)	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Home Health Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Hospice Care	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Durable Medical Equipment	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Ambulance	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Radiation Therapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chemotherapy	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^	Deductible, then CIF^
Chiropractor Visits	Deductible, then CIF^ 12 visits per plan year	Deductible, then CIF^ 12 visits per calendar year	Deductible, then CIF^ 12 visits per plan year	Deductible, then CIF^ 12 visits per plan year
Prescription Drugs	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**	**Retail Pharmacy: Copays AFTER DEDUCTIBLE**
(Inpatient drugs paid in full)	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay	Tier 1: $10.00 copay Tier 2: $30.00 copay Tier 3: $65.00 copay (up to a 30-day supply) **Mail Order: (up to 90 day supply) Copays AFTER DEDUCTIBLE** Tier 1: $25.00 copay Tier 2: $75.00 copay

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BENEFIT	YOU PAY	YOU PAY	YOU PAY	YOU PAY
	Tier 3: $165.00 copay	Tier 3: $165.00 copay	Tier 3: $165.00 copay	Tier 3: $165.00 copay

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PLAN TYPE				
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Fitness Benefit	**Reimbursement**	**Reimbursement**	**Reimbursement**	**Reimbursement**
	Fitness reimb up to **$150** per subscriber at a Health & Fitness club per calendar year. Must be an active member of HPHC for at least 4 months and an active member of the health facility for at least 4 months. See plan materials for details.	Up to $300 reimbursement toward health club membership or exercise classes. See plan materials for details.	Fitness reimb up to **$150** per subscriber at a Health & Fitness club,including exercise classes per calendar year. See plan materials for details.	It Fits! Program reimburses families on Select Care up to **$400** per family contract (**$200** for individual contracts)and Direct Care members up to **$500** per family contract (**$250** for individual contracts) to use toward health club memberships, Pilates, Yoga classes Weight Watchers® programs, and local, school sports programs and now fitness related equipment.
	Discounts at IFCN-affiliated clubs. Discount at Weight Watchers®	Enroll in a qualified Weight Watchers® or hospital based weight loss program and receive up to $150 per calendar year toward your program fees.	JENNY CRAIG DISCOUNTS: -FREE 30 DAY PROGRAM -25% OFF A PREMIUM/METABOLIC PROGRAM NUTRISYSTEM DISCOUNT: -12% DISCOUNT - OFF CURRENT PROMO -CORE OR SELECT PROGRAM	The equipment must be new, purchased from a retail store and not Craig's List or EBay. Other discounts also available. See plan materials for details.

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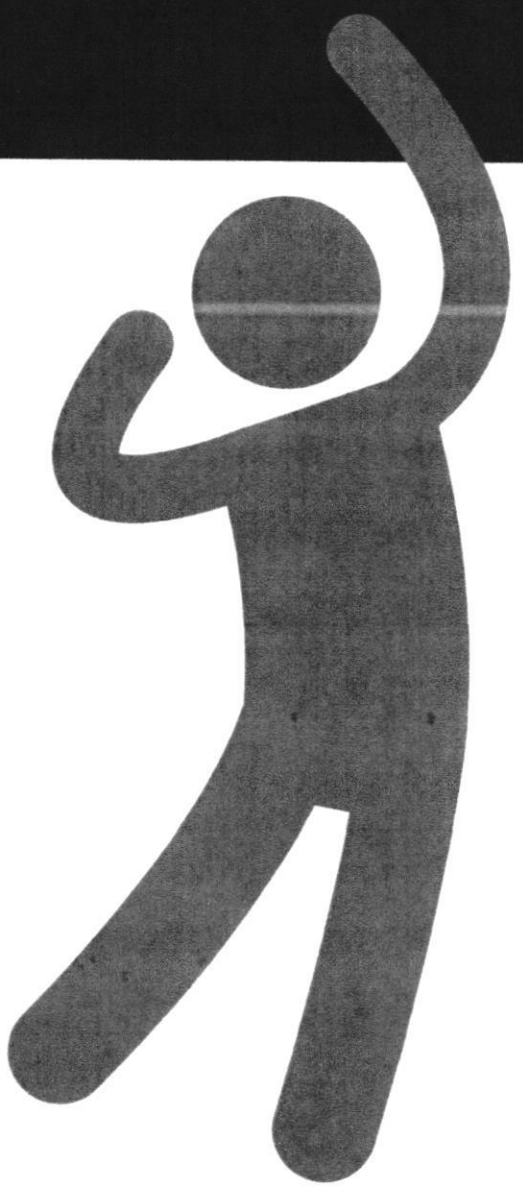
WINNING WITH AN HSA

Health savings accounts (HSAs)



HSAs: the *new* RETIREMENT **STRATEGY**

SAVE NOW AND FOR THE FUTURE

HealthEquity

HealthEquity

HSAs ARE AN EASY WIN

in today's complex healthcare system

How an HSA works

An HSA paired with an HSA-qualified health plan allows you to make tax-free[1] contributions to an federally-insured[2] savings account. Balances earn tax-free interest and can be used to pay for qualified medical expenses. HSA-qualified health plans typically cost less than traditional plans and the money saved can be put into your HSA.

HSAs empower savings:

- Lower monthly health insurance premiums
- Money put into your HSA is not taxed
- You earn tax-free interest on HSA balances
- HSA funds used for qualified medical expenses are not taxed
- You can invest your HSA funds for increased tax-free earning potential[3]

HSA funds remain yours to grow

With an HSA, you own the account and all contributions. Unlike flexible spending accounts (FSAs), the entire HSA balance rolls over each year and remains yours even if you change health plans, retire or leave your employer.

You can win with an HSA

Regardless of your personal medical situation, an HSA can empower you to maximize savings while building a reserve for the future. Contrary to what many may think, healthy individuals aren't the only users who benefit from an HSA.

HSAs are never taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-free with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

Your HSA cash balance is held at an FDIC-insured or NCUA-insured institution and is eligible for federal deposit insurance, subject to applicable requirements and limitations.

Investments are subject to risk, including the possible loss of the principal invested, and are not FDIC or NCUA insured, nor guaranteed by HealthEquity, Inc. Investing through the HealthEquity investment platform is subject to the terms and conditions of the HealthEquity Account Custodial Agreement and the applicable investment supplement. Investing may not be suitable for everyone and before making any investments, review the fund's prospectus.

HealthEquity

HSAs: THE NEW RETIREMENT STRATEGY

Supplement your retirement

The average American couple will need $265,000[1] to cover out-of-pocket health care costs in retirement. An HSA can help fill this Medicare gap as well as dental, hearing and vision expenses. Qualified medical expenses remain tax-free,[2] even into retirement. In addition, after age 65, you can use your HSA much like a 401(k) and withdraw funds for any purpose.[3]

Invest[4] your HSA to maximize your tax-free earning potential

Once your account balance reaches $2,000,[5] you can increase your earning potential by investing any funds over that amount in mutual funds. A comprehensive line-up of mutual funds is offered with options designed to fit your individual needs.

Take the guesswork out of investing with Advisor™ (Powered by HealthEquity ADVISORS LLC)

You can manage investments on your own or let Advisor[6] do all of the work. Advisor powered by HealthEquity Advisors, LLC can provide web-based guidance designed to diversify your portfolio and can even manage the trading of mutual funds for you. Investment advice and portfolio management is based on your personal risk preferences, age and financial goals. Additional fees apply.

For more information about investing with Advisor, visit:

HealthEquity.com/Advisor

HealthEquity

GET STARTED WITH AN HSA TODAY

1 Select an HSA-qualified health plan

Enroll in an HSA-qualified plan. These plans typically cost less than traditional plans and provide tax saving opportunities. HealthEquity will work with your employer or health plan to automatically set up your account and supply a HealthEquity® Visa® Health Account Card[1] to conveniently pay for eligible expenses.

2 Add money to your HSA

Fund your HSA through pre-tax payroll deductions or transfer money into your account through the HealthEquity member portal. To take full advantage of tax savings and to build a reserve for the future, consider maximizing your contributions as set by the IRS:

HSA eligibility

To make tax-free[2] contributions to an HSA, the IRS requires that:

- you are covered by an HSA-qualified health plan.
- you have no other health coverage (such as other health plan, Medicare, military health benefits, medical FSAs).
- you cannot be claimed as a dependent on another person's tax return.

HSA CONTRIBUTION LIMITS

2019 INDIVIDUAL $3,500	2020 INDIVIDUAL $3,550
2019 FAMILY $7,000	2020 FAMILY $7,100

At age 55, an additional **$1,000** is allowed annually.

This card is issued by The Bancorp Bank, member FDIC pursuant to a license from Visa U.S.A. Inc. Your card can be used everywhere Visa debit cards are accepted for qualified expenses. This card cannot be used at ATMs and you cannot get cash back and cannot be used at gas stations, restaurants, or other establishments not health related. See Cardholder Agreement for complete usage restrictions.

HSAs are not taxed at a federal income tax level when used appropriately for qualified medical expenses. Also, most states recognize HSA funds as tax-free with very few exceptions. Please consult a tax advisor regarding your state's specific rules.

3 Watch your HSA grow

Your federally-insured HSA earns tax-free[1] interest. Maximize your tax-free earning potential by investing HSA funds using the convenient online investment tool.[2]

4 Use your HSA for qualified medical expenses

HSA funds can be used for a variety of qualified medical, dental and vision expenses, including:

- Acupuncture
- Birth control
- Chiropractor
- Contact lenses
- Dental treatment
- Prescription eyeglasses
- Fertility enhancement
- Hearing aids
- Lab work
- Medical supplies
- Physical exams
- Prescriptions
- Orthodontia
- Radiology
- Stop-smoking programs
- Surgery (non-cosmetic)
- Therapy
- and more...

You will receive a HealthEquity debit card for easy access to your funds.

For an expanded list of qualified medical expenses, visit:

HealthEquity.com/qme

Who are you?

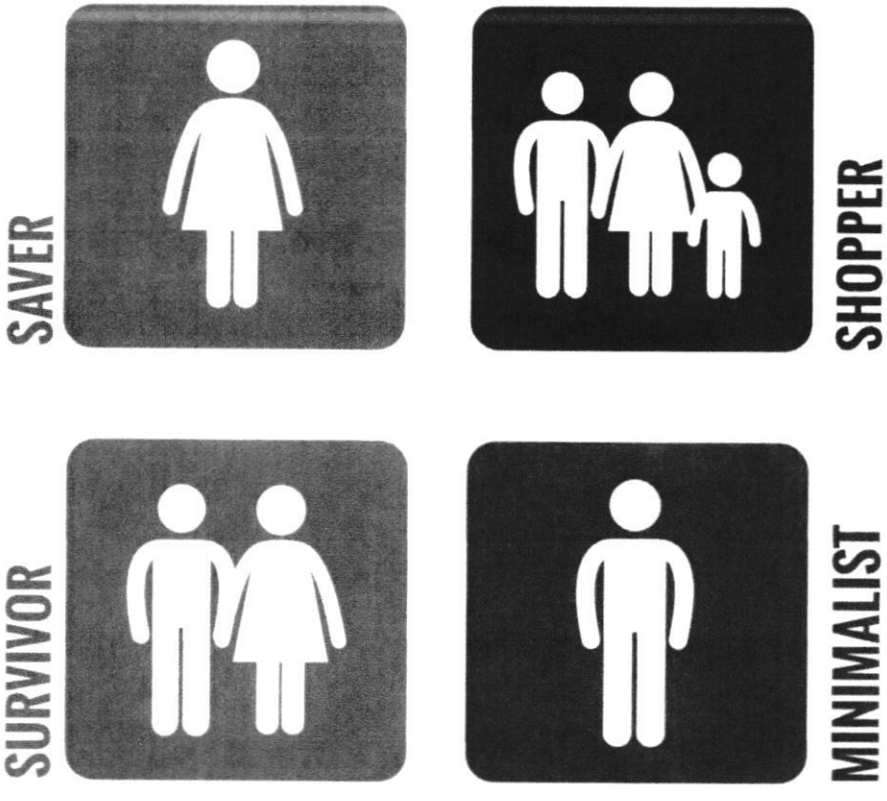
HealthEquity

YOU CAN WIN WITH AN HSA

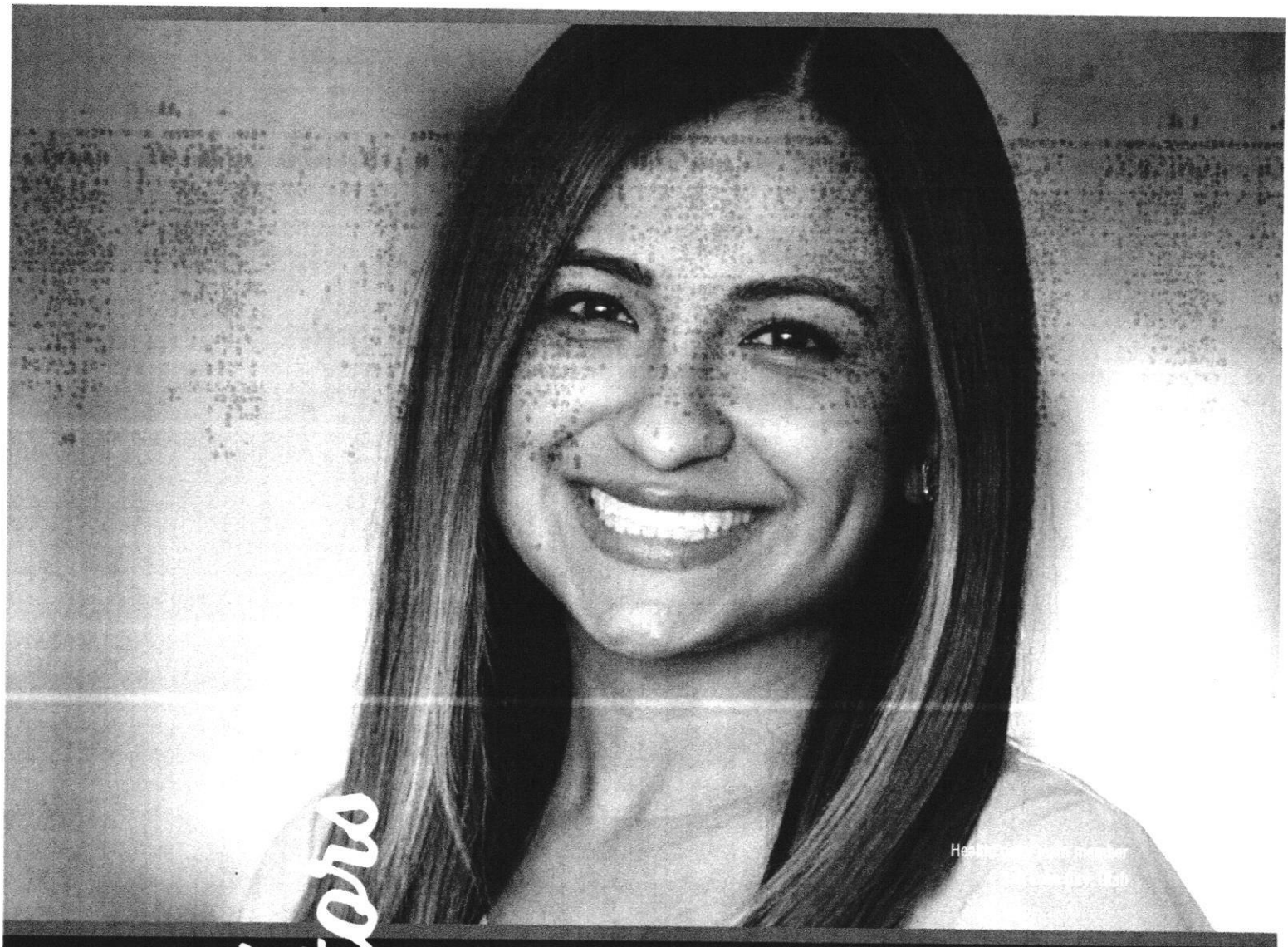
An HSA can benefit Americans from all walks of life and empower savings now and for the future. Contrary to popular belief, you do not have to be healthy or wealthy to benefit from an HSA – just wise! To see how different types of healthcare consumers win, see the link below.

See how *you* can personally benefit from an HSA:

HealthEquity.com/Me



HealthEquity



Account mentors

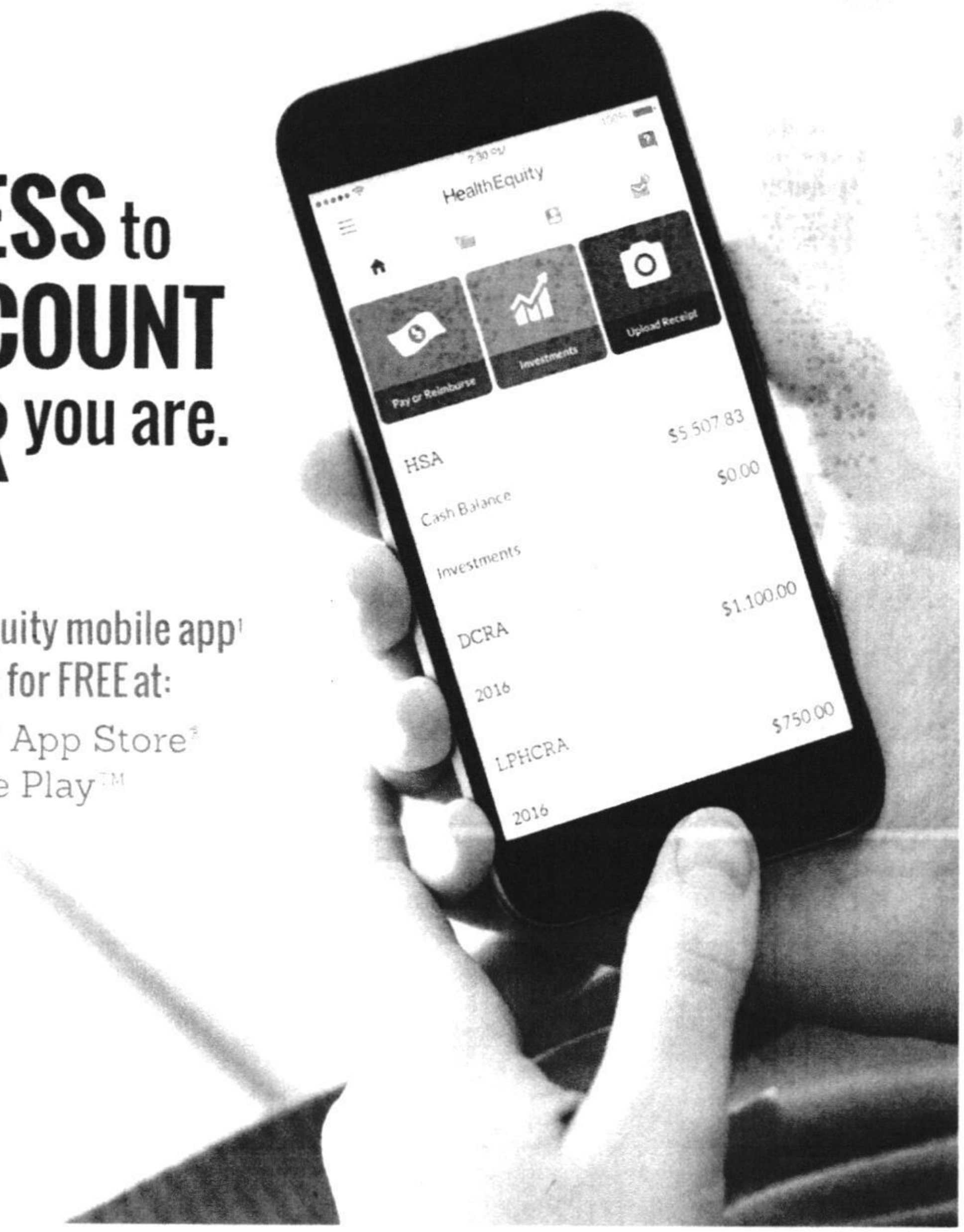
We are available to help, every hour of every day

We understand the significance of your benefits selection. Our team of specialists based in Salt Lake City is available 24 hours a day, providing you with insight to help you optimize your health savings account. Call today.

866.346.5800

HealthEquity.com/HSAlearn

EASY ACCESS to your ACCOUNT WHEREVER you are.



HealthEquity mobile app[1] available for FREE at:

- Apple® App Store®
- Google Play™

HealthEquity®

15 West Scenic Pointe Drive
Draper, UT 84020
info@healthequity.com | www.HealthEquity.com

Town of Shrewsbury 2020 - 2021 Employee Payroll Agreement

I _____ authorize the Town of Shrewsbury to deduct the premiums designated below from my payroll check.

Pay Frequency	26-Bi-Weekly Town Departments			26-Bi-Weekly Teachers			26-Bi-Weekly School Administrators			21-Bi-Weekly Aides, ABAs, Ext. Day, and Food Svcs.		
Benchmark Plans	EMP	TOWN		EMP	TOWN		EMP	TOWN		EMP	TOWN	
BC/BS												
Individual	___ $197.17	$295.75	8260	___ $197.17	$295.75	8261	___ $197.17	$295.75	8264	___ $244.11	$366.17	8263
Family	___ $528.55	$792.83	8250	___ $528.55	$792.83	8251	___ $528.55	$792.83	8254	___ $654.40	$981.60	8253
Tufts												
Individual	___ $200.12	$300.18	8280	___ $200.12	$300.18	8281	___ $200.12	$300.18	8284	___ $247.77	$371.66	8283
Family	___ $523.94	$785.91	8270	___ $523.94	$785.91	8271	___ $523.94	$785.91	8274	___ $648.69	$973.03	8273
HPHC												
Individual	___ $190.15	$285.23	8230	___ $190.15	$285.23	8231	___ $190.15	$285.23	8234	___ $235.43	$353.14	8233
Family	___ $495.32	$742.98	8210	___ $495.32	$742.98	8211	___ $495.32	$742.98	8214	___ $613.26	$919.89	8213
Fallon Select												
Individual	___ $98.45	$266.17	8330	___ $98.45	$266.17	8331	___ $98.45	$266.17	8334	___ $121.89	$329.54	8333
Family	___ $265.31	$717.31	8310	___ $265.31	$717.31	8311	___ $265.31	$717.31	8314	___ $328.47	$888.10	8313
Fallon Direct												
Individual	___ $74.73	$264.96	8430	___ $74.73	$264.96	8431	___ $74.73	$264.96	8434	___ $92.53	$328.05	8433
Family	___ $201.05	$712.80	8410	___ $201.05	$712.80	8411	___ $201.05	$712.80	8414	___ $248.91	$882.51	8413
HDHP (HSA) Plans	EMP	TOWN		EMP	TOWN		EMP	TOWN		EMP	TOWN	
BC/BS												
Individual	___ $159.14	$238.71	8051	___ $159.14	$238.71	8061	___ $159.14	$238.71	8071	___ $197.03	$295.54	8081
Family	___ $427.38	$641.08	8052	___ $427.38	$641.08	8062	___ $427.38	$641.08	8072	___ $529.14	$793.71	8082
Tufts												
Individual	___ $154.89	$232.34	8053	___ $154.89	$232.34	8063	___ $154.89	$232.34	8073	___ $191.77	$287.66	8083
Family	___ $405.78	$608.68	8054	___ $405.78	$608.68	8064	___ $405.78	$608.68	8074	___ $502.40	$753.60	8084
HPHC												
Individual	___ $147.14	$220.71	8055	___ $147.14	$220.71	8065	___ $147.14	$220.71	8075	___ $182.17	$273.26	8085
Family	___ $384.00	$576.00	8056	___ $384.00	$576.00	8066	___ $384.00	$576.00	8076	___ $475.43	$713.14	8086
Fallon Select												
Individual	___ $82.87	$224.05	8057	___ $82.87	$224.05	8067	___ $82.87	$224.05	8077	___ $102.60	$277.40	8087
Family	___ $223.68	$604.78	8058	___ $223.68	$604.78	8068	___ $223.68	$604.78	8078	___ $276.94	$748.77	8088
Fallon Direct												
Individual	___ $62.95	$223.20	8059	___ $62.95	$223.20	8069	___ $62.95	$223.20	8079	___ $77.94	$276.34	8089
Family	___ $169.67	$601.56	8060	___ $169.67	$601.56	8070	___ $169.67	$601.56	8080	___ $210.07	$744.79	8090
Indemnity Plans	EMP	TOWN		EMP	TOWN		EMP	TOWN		EMP	TOWN	
HPHC PPO												
Individual	___ $613.38	$613.38	8160	___ $613.38	$613.38	8161	___ $613.38	$613.38	8164	___ $759.43	$759.43	8163
Family	___ $1,362.00	$1,362.00	8150	___ $1,362.00	$1,362.00	8151	___ $1,362.00	$1,362.00	8154	___ $1,686.29	$1,686.29	8153
Life Insurance	EMP	TOWN		EMP	TOWN		EMP	TOWN		EMP	TOWN	
Basic Life	___ $1.96	$1.96	8904	___ $1.96	$1.96	8902	___ $1.96	$1.96	8905	___ $2.42	$2.42	8903
Optional Life	___ $_____		8915	$_____		8916	$_____		8917	$_____		8918
	Formula: Rate $_____ x Ins. Total per 1,000 $_____ x 12 / _____ (pay frequency)											
Voluntary Life	___ $_____		8930	___ $_____		8931	___ $_____		8934	___ $_____		8933
Town Dental Ins	EMP	TOWN										
Altus Dental	(24 week)											
Individual	___ $24.31	$0.00	8970	___ NA			___ NA			___ NA		
Family	___ $62.51	$0.00	8971	___			___			___		

I understand that if my premiums are not deducted correctly from my payroll/retirement check it is my responsibility to notify the Town Benefits Administrator, and I will be responsible for all back premiums. I also understand that the Town deducts premium one month in advance of coverage and additional premium due upon initial enrollment will also be deducted from my first payroll/retirement check. I acknowledge that I have received a notice informing me of my right under COBRA (Consolidated Omnibus Budget Reconciliation Act). I also acknowledge that I have received the Town of Shrewsbury's HIPAA Privacy Policy.

EFFECTIVE DATE: _____

SIGNED: _____ **DATED:** _____

Health Insurance Enrollment Forms
(Complete the plan of your choice)

- Fallon
- Harvard Pilgrim
- Tufts
- Blue Cross

Fallon Community Health Plan Employer Group Membership Transaction Form

Please complete all fields on form. (Please print clearly.)

PLEASE CHOOSE YOUR PROVIDER NETWORK

❑ FCHP DIRECT CARE ❑ FCHP SELECT CARE Plan name (if applicable): ____________________

EMPLOYEE INFORMATION — IF WE MAY CONTACT YOU BY E-MAIL, PLEASE SUPPLY ADDRESS WHERE INDICATED.*

NAME (LAST, FIRST, MI)			MAIDEN NAME (IF APPLICABLE)		PRIMARY LANGUAGE
STREET ADDRESS	CITY		STATE	ZIP CODE	HOME PHONE ( )
BIRTH DATE	SEX ❑ M ❑ F	RACE ❑ WHITE ❑ BLACK ❑ HISPANIC ❑ ASIAN/PACIFIC ISLANDER ❑ AMERICAN INDIAN/ALASKAN NATIVE ❑ OTHER			
WORK PHONE ( )	*E-MAIL	SOCIAL SECURITY NO.	STATUS ❑ FULL-TIME ❑ PART-TIME ❑ RETIRED ❑ COBRA		
DATE HIRED	AVERAGE NO. HOURS WORKED	DEPARTMENT #	EMPLOYEE #	IS YOUR SPOUSE EMPLOYED? ❑ YES ❑ NO	PRIMARY CARE PHYSICIAN SELECTION

EVER TREATED BY THIS PHYSICIAN? ❑ NO
(IF YES, UNDER WHAT NAME?) ❑ YES ____________________

IF CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE TO ADD SPOUSE, GIVE DATE OF MARRIAGE / /

DEPENDENT INFORMATION

PRIMARY CARE PHYSICIAN (PCP) SEE PROVIDER LIST

NAME OF DEPENDENT (LAST/FIRST/MI – MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE / /	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO
*E-MAIL		RACE	
NAME OF DEPENDENT (LAST/FIRST/MI – MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE / /	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO
*E-MAIL		RACE	
NAME OF DEPENDENT (LAST/FIRST/MI – MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE / /	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO
*E-MAIL		RACE	
NAME OF DEPENDENT (LAST/FIRST/MI – MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE / /	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO
*E-MAIL		RACE	
NAME OF DEPENDENT (LAST/FIRST/MI – MAIDEN NAME IF APPLICABLE)	❑ M ❑ F	SOCIAL SECURITY NO.	PCP SELECTION
RELATION	BIRTHDATE / /	PRIMARY LANGUAGE	EVER TREATED BY THIS DOCTOR? ❑ YES ❑ NO
*E-MAIL		RACE	

GROUP INFORMATION

GROUP NUMBER

GROUP NAME WSHG Town of Shrewsbury

REQUESTED EFFECTIVE DATE

TYPE OF COVERAGE
❑ INDIVIDUAL ❑ FAMILY
❑ OTHER ____________

REASON FOR TRANSACTION

ADDING COVERAGE
- ❑ New hire
- ❑ Annual open enrollment
- ❑ Other (explain in "Remarks" section below)

ENDING COVERAGE
- ❑ Termination of employment
- ❑ Change to other insurance (give name of other insurance in "Remarks" section below)
- ❑ Other (explain in "Remarks" section below)

CHANGES TO EXISTING COVERAGE

Change to:
- ❑ Individual ❑ Family ❑ Other
- ❑ Addition of a dependent (complete "Dependent" section above)
- ❑ Change in name, address, or other application information (give previous information in "Remarks" section below)
- ❑ COBRA
- ❑ Other (explain in "Remarks" section below)

REMARKS

AGREEMENT (SUBSCRIBER'S SIGNATURE)

I agree to the terms and conditions located on the back of this form.

X ____________________

For FCHP Use Only	Territory	Receipt Date	Employer's Signature	Date

Benefits Administrator: Mail white and yellow copies to FCHP Service Operations, 10 Chestnut St., Worcester, MA 01608. Pink copy is for employee.

08-715-200 Rev. 02 9/09

Temporary Membership Card

WELCOME! Thank you for choosing Fallon Community Health Plan (FCHP) for your health coverage. You will soon receive a New Member Kit in the mail. This kit will include information on your membership in FCHP and your membership card(s). In the meantime, this sheet is your **temporary membership card.** Also included in this kit will be information on how to obtain a *Member Handbook/Evidence of Coverage*, which defines your benefits and regulates benefit decisions. NOTE: The requested effective date may not be the actual effective date if it is not in accordance with the FCHP Group Agreement and the FCHP Direct Care or FCHP Select Care *Member Handbook/Evidence of Coverage.*

CHOOSING YOUR PHYSICIAN: At the time of enrollment, you also must select a primary care physician for every person covered under this contract: a doctor of internal medicine or family practice for adults and a pediatrician or family practice doctor for children. Please refer to fchp.org or your FCHP Direct Care or FCHP Select Care *Provider Network* directory for a complete list of providers and their locations. You must make these selections now and list your choices on this Membership Transaction Form. If you wish to notify us of a physician change or if you need help choosing a physician, please call the Customer Service Department at 1-800-868-5200 (TDD/TTY: 1-877-608-7677). To make an appointment, call your doctor's office or medical center directly.

EMERGENCY CARE: *Emergency services do not require referral or authorization.* When you have an emergency medical condition, you should go to the nearest emergency department or call your local emergency communications system (police, fire department, or 911). If you receive care outside of the plan service area, Fallon Community Health Plan requires you to notify the plan within 48 hours or as soon as is medically possible. For more information on emergency benefits and plan procedures for emergency services, consult your *Member Handbook/Evidence of Coverage.*

OUT-OF-AREA CARE: When you are out of the service area, you are covered for any unexpected illness or injury that needs prompt medical attention. Call FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677) to report use of services, and call your doctor to arrange for follow-up care.

REMEMBER: FCHP will not pay for any services that are not provided or appropriately arranged by Fallon Community Health Plan, except in life-threatening emergencies in the area or any emergencies out of the service area.

CONSENT: Submission of this form indicates that you authorize anyone who provides medical services to you, your spouse or dependents to release to the plan any health information or medical records relating to those services for such routine needs as coordination of benefits, disease management programs, quality management, coordination of care, health services management, accreditation, processing and payment of related claims.

AGREEMENT: I am employed by the company named on this form, working at least 30 hours per week, full time, or 20 hours part time, and I receive employer contribution to health insurance coverage (or I am otherwise eligible for the named company's health insurance coverage, e.g., as a former employee covered under COBRA). I hereby authorize my employer to deduct from my wages (if necessary) the amount I am responsible for contributing for the FCHP coverage I have selected. I understand that FCHP is a health maintenance organization and that membership becomes effective in accordance with the FCHP Group Agreement and the *Member Handbook/Evidence of Coverage.* I have read this Membership Transaction Form and understand how to obtain and use services under my FCHP coverage. I certify that all information is correct to the best of my knowledge.

QUESTIONS ABOUT COVERAGE? Call FCHP Customer Service at 1-800-868-5200 (TDD/TTY: 1-877-608-7677), or visit our Web site at fchp.org.

WELCOME TO TUFTS HEALTH PLAN

TUFTS Health Plan

New Members — Register at Tuftshealthplan.com for fast access to your secure online account and personal benefit information.

Please fill in the "employee" sections of this membership application completely. Failure to do so could delay enrollment. You will receive your Tufts Health Plan ID card and member benefit document soon. If you need a temporary ID, please use the yellow copy of this completed form.

Employer Section

Your employer must fill out this section.

Employee Section

- Personal Information: Complete all enrollment information. If your plan (HMO, POS, or EPO) requires the selection of a primary care provider (PCP), be sure to fill out this section for all members, including dependents.
- Product Code: Please be sure to fill in the correct product code for the plan you have selected.
- Primary Care Provider: If your plan requires you to choose a PCP, it is important that you select one right away. Until we know who your PCP is, your in-network benefits may be limited to emergency services only. To find a PCP, visit tuftshealthplan.com and use the Doctor Search feature. On this application, indicate whether you are an established patient of the PCP you have listed. (You are an established patient if you have routinely received health care services from this provider in the past.) If you are selecting a new PCP, contact the provider's office right away and introduce yourself as a new Tufts Health Plan member. Ask if they are taking new patients and if the provider would like to schedule a physical exam. You will then need to transfer your medical records to your new PCP.
- Other Health Coverage: If you have other or additional insurance (such as Medicare), please check the correct box and fill in the requested information. If you do not have any other insurance, be sure to check the "No" box.

When the Application is Complete

- Give the application to your employer.
- Employee keeps the yellow copy. This is also your temporary ID.
- Employer keeps the pink copy.
- Employer mails the original white copy to:
  Tufts Health Plan
  P.O. Box 9186
  Watertown, MA 02471-9186

If You Need Emergency Care

If a health care emergency occurs, go to the nearest medical facility or call 911. An emergency is a serious injury or the onset of a serious condition that prevents you from taking the time to call your PCP.

Notices

By enrolling, you understand and agree that if you or any of your enrolled dependents obtain a health care benefit or payment that you are not entitled to receive, or if you knowingly present a claim that contains a false statement, you can be liable for the full amount of the health care benefit or payment made and for reasonable attorney's fees and costs, including the cost of the investigation.

Tufts Health Plan arranges for the provision of health care services through agreements with independent community-based health care professionals working in private offices and with hospitals throughout the Tufts Health Plan service area. These providers are independent contractors and not employees, agents, or representatives of Tufts Health Plan. Tufts Health Plan does not directly provide health care services.

Product Codes

Write the corresponding letter in the product box in the member section of the enrollment application.

A - HMO Premium
B - HMO Value
C - HMO Basic
D - HMO Choice Copay
E - Advantage HMO
G - Advantage HMO Saver
H - POS
I - POS Choice Copay
J - EPO
K - EPO Choice Copay
L - PPO
M - Advantage PPO
O - Advantage PPO Saver
P - Navigator by Tufts Health Plan
Q - Carelink
R - HMO Select 15
S - HMO Select 20
T - Advantage HMO Select 750
U - Advantage HMO Select 2000
W - Rhode Island Healthpact
X - Your Choice HMO
Y - Your Choice PPO
Z - Steward Community Choice
RIC - Rhode Island Conversion

We speak 140 languages. Call Member Services.

Nous parlons français
Hablamos Español
Nós falamos português
Мы говорим по-русски
Parliamo Italiano
Wir sprechen Deutsch
我們會講普通話
我們會講廣東話
Chúng tôi nói được tiếng Việt
Nou pale Kreyòl
เรา [illegible]

Need Help?

If you need assistance selecting a PCP, visit tuftshealthplan.com and use the Doctor Search feature. If you need help filling out this form, call a Member Services Specialist.

Member Services:
800-462-0224

18079-12/11

MEMBER ENROLLMENT FORM

TUFTS Health Plan

Please print clearly or type. Please be sure application is completed in full to ensure enrollment. Employers can mail completed forms to: Tufts Health Plan • P.O. Box 9186 • Watertown, MA 02471-9186

FAILURE TO COMPLETE AREAS MARKED IN BLUE WILL CAUSE A DELAY IN ENROLLMENT.

EMPLOYER SECTION

Group/Company Name _____ Group Number _____

Office Location _____ Date of Hire _____ Effective Date of Coverage _____

Type of Enrollment: ❑ New Hire ❑ Open Enrollment ❑ COBRA ❑ New Group ❑ Qualifying Event (MUST specify) _____ Qualifying Event Date _____

MEMBER SECTION

PRODUCT (Select corresponding letter from the list on the front page) _____ Other _____

Last Name _____ First Name _____ Middle Initial _____ Primary Language _____

Employee Social Security Number (required) _____ Date of Birth (MM/DD/YYYY) _____ / _____ / _____ Gender: ❑ Male ❑ Female

Mailing (Home) Address _____ City _____ State _____ ZIP _____ Home Telephone (____) _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Domestic Partner Type of Coverage Requested: ❑ Individual ❑ Family ❑ Other _____ Work Telephone (____) _____

Primary Care Provider (HMO, POS, EPO only) First Name _____ Last Name _____ PCP ID# _____ Are you an established patient of this PCP? ❑ Yes ❑ No

Members Enrolling (First name, include last name if different)	Sex M/F	Date of Birth (MM/DD/YEAR)	Social Security Number	Choose a Primary Care Provider for each member (HMO, POS, EPO only. Include first and last name.)	Check if currently used for primary care	PCP ID #
❑ Spouse ❑ Domestic Partner			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	
Child/Dependent			- -		❑	

Please check if you are using additional membership applications for additional dependent children. ❑

Do you or someone else covered under this insurance policy have other health insurance coverage at the same time your Tufts Health Plan policy is in effect? ❑ Yes ❑ Yes (Medicare) ❑ No

Name of Health Plan _____ Name of Plan Holder _____ Health Plan Number _____ Effective Date _____

Names of Family Members Covered _____ Is Spouse Employed? ❑ Yes ❑ No If Yes, Name and Address of Employer _____

The information supplied on this form is true and complete. I authorize my employer to make necessary payroll deductions, if any, for my share of Tufts Health Plan coverage. I assign benefits to Tufts Health Plan providers, which means that Tufts Health Plan is authorized to make payments directly to Tufts Health Plan providers for services rendered to me (us). I grant Tufts Health Plan any legal right that I (we) may have to recover the cost of services for an illness or injury caused by someone else when these services have been or will be paid by Tufts Health Plan. I understand that calls to the Member Services department may be monitored for quality assurance. I understand that the benefits for which I (we) are eligible are those described in the applicable member benefit documents.

Signature (required) _____ Date _____ Benefits Dept. Signature _____ Telephone _____ Date _____

WHITE - TUFTS HEALTH PLAN COPY PINK - EMPLOYER COPY YELLOW - SUBSCRIBER COPY. Please keep yellow copy as your temporary Tufts Health Plan ID

Harvard Pilgrim Health Care

P.O. Box 9185 Quincy, MA 02269

REASONS FOR SUBMISSION {PLEASE CHECK ONE}

☐ NEW ENROLLMENT/CONTRACT
☐ CHANGE TO CONTRACT
☐ TERMINATE CONTRACT

QUALIFYING EVENT DATE:

☐ OPEN ENROLLMENT ☐ NEW HIRE ☐ COBRA ☐ LOSS OF INSURANCE ☐ COURT ORDER ☐ BIRTH/ADOPTION ☐ P/T TO F/T ☐ MARRIAGE/DIVORCE ☐ MOVED IN/OUT OF SERVICE AREA ☐ DEATH ☐ VOLUNTARY CANCELLATION

REASON FOR CHANGES {CHECK ALL THAT APPLY}

☐ CHANGE COVERAGE TYPE ☐ ADD DEPENDENT LISTED ☐ TERMINATE DEPENDENT LISTED ☐ TRANSFER/RE-ENROLL TO COBRA
☐ OTHER:

EMPLOYER/GROUP INFO (TO BE COMPLETED BY EMPLOYER)

EMPLOYER/GROUP NAME	GROUP #DIVISION	DATE OF HIRE	EFFECTIVE DATE OF COVERAGE

SUBSCRIBER INFORMATION

HP ID | PRODUCT ☐ HMO ☐ PPO ☐ POS ☐ ACCESS AMERICA | PLAN NAME

SUBSCRIBER FIRST NAME | MI | LAST NAME | DOB | GENDER ☐ M ☐ F

SSN | HOME PHONE | WORK PHONE | CELL PHONE | EMAIL

STREET ADDRESS (NO PO BOX for HMO allowed) | APT # | CITY | STATE | ZIP

PRIMARY LANGUAGE (OPTIONAL) | PCP FULL NAME | PCP TOWN | CURRENT PATIENT ☐ YES ☐ NO | PCP ID #

SPOUSE INFORMATION

SPOUSE FIRST NAME | MI | LAST NAME | DOB | GENDER ☐ M ☐ F

SSN | MAILING ADDRESS (IF DIFFERENT) | RELATION CODE

PCP FULL NAME | PCP TOWN | CURRENT PATIENT ☐ YES ☐ NO | PCP ID #

DEPENDENT INFORMATION

DEPENDENT FIRST NAME | MI | LAST NAME | DOB | GENDER ☐ M ☐ F | RELATION CODE

MAILING ADDRESS (IF DIFFERENT) | SSN

PCP FULL NAME | PCP TOWN | CURRENT PATIENT ☐ YES ☐ NO | PCP ID#

DEPENDENT INFORMATION

DEPENDENT FIRST NAME | MI | LAST NAME | DOB | GENDER ☐ M ☐ F | RELATION CODE

MAILING ADDRESS (IF DIFFERENT) | SSN

PCP FULL NAME | PCP TOWN | CURRENT PATIENT ☐ YES ☐ NO | PCP ID#

DEPENDENT INFORMATION

DEPENDENT FIRST NAME | MI | LAST NAME | DOB | GENDER ☐ M ☐ F | RELATION CODE

MAILING ADDRESS (IF DIFFERENT) | SSN

PCP FULL NAME | PCP TOWN | CURRENT PATIENT ☐ YES ☐ NO | PCP ID#

☐ PLEASE CHECK IF USING ADDITIONAL MEMBERSHIP APPLICATIONS FOR DEPENDENT CHILDREN. BE SURE TO COMPLETE EMPLOYER AND SUBSCRIBER SECTIONS ON ADDITIONAL FORMS

OTHER INSURANCE – *IF YOU HAVE NOT COMPLETED THIS SECTION, YOU MAY RECEIVE A FOLLOW-UP QUESTIONNAIRE AND CLAIMS MAY BE DELAYED.*

ARE YOU OR ANYONE LISTED ABOVE COVERED BY ANOTHER HEALTH INSURANCE POLICY AT THE SAME TIME YOUR HPHC POLICY IS IN EFFECT? ☐ YES, PLEASE COMPLETE ☐ NO

NAME OF HEALTH PLAN	HEALTH PLAN ID NUMBER	EFFECTIVE DATE	NAMES OF SUBSCRIBER

MEMBERSHIP WILL BECOME EFFECTIVE UPON ACCEPTANCE BY HARVARD PILGRIM. BENEFITS UNDER THE PLAN WILL BE EXPLAINED IN YOUR EVIDENCE OF COVERAGE (EOC). I UNDERSTAND THAT HARVARD PILGRIM MAY OBTAIN PERSONAL AND MEDICAL INFORMATION TO ADMINISTER THE PLAN. FOR AN EXPLANATION OF HOW WE MAY USE OR DISCLOSE PROTECTED HEALTH INFORMATION, PLEASE READ YOUR NOTICE OF PRIVACY PRACTICES. MAINE MEMBERS: YOU UNDERSTAND THAT YOUR EOC INCLUDES A SUBROGATION PROVISION THAT PERMITS SUBROGATION PAYMENTS TO US ON A JUST AND EQUITABLE BASIS. IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR DENIAL OF INSURANCE BENEFITS.

EMPLOYEE SIGNATURE DATE EMPLOYER SIGNATURE DATE

NH 7458 0718

Thank you for choosing Harvard Pilgrim Health Care.

Please read the following instructions prior to completing this enrollment/change form. This form may be used for all enrollment transactions (Adding coverage, changing coverage, terminating coverage). In order to add, change or terminate coverage you must (1) experience a qualifying event, (2) complete this enrollment, and (3) provide the completed form to your employer within the allowed timeframe or approved retroactive period.

Qualifying Events:

New Enrollment	**Contract change**	**Termination**
Open Enrollment	Open Enrollment	Open Enrollment
New hire date	Marriage/Divorce	Voluntary Cancellation
Probationary Period (if applicable)	Birth/Adoption/Court Order	Left Employment
Loss of Insurance	Loss of Insurance	Moved from Area
Employment Status Change	Loss of Employer Premium contributions	No Longer Eligible (e.g. deceased, LOA, laid off, COBRA nonpayment)

Employer Section: Your Employer must fill out this section as well as the Reason for Submission in full for any transactions that this form is used for.

Member Section: Please complete all of the employee sections of this membership application in full. Failure to do so could delay enrollment. You will receive your ID card(s) and member benefit documents after your enrollment has been fully processed. If you are adding or removing a dependent(s), just include the details about the dependent(s) that you are adding or removing off the plan.

- **Product/Plan Name:** Please be sure to fill in the correct product code for the plan you have selected. Your options are HMO, POS, PPO and Access America. If your employer offers multiple Harvard Pilgrim Plans, please indicate the Plan name as listed on the enrollment materials to help clearly differentiate the plan you are choosing. If you know the Plan MD # (MD0000016670) the number to identify the plan/product please include the information.
- **Personal Information:** In addition to yourself, please include the personal information for every dependent that will be enrolled on the Plan. ***IMPORTANT: Social security numbers (or personal tax identification number) for each member on the plan are needed to ensure that federal regulatory reporting requirements are met. Social security numbers are not displayed on the member's ID card.***
- **Primary Care Provider:** If your plan is an HMO, you will need to select a primary care provider (PCP). If your plan requires one, it is important that you choose a PCP right away. Be sure to fill out this section for all members, including dependents. Write the Harvard Pilgrim PCP ID (not the phone number) and the full name of the doctor you have chosen to coordinate your health care without a PCP assignment, your in-network benefits may be limited to emergency services only. To find a PCP or lookup the PCP ID, visit www.harvardpilgrim.org, and use the doctor search feature available in the Member Section.
- **Relation Code:** Please use one of the following codes to designate the dependent's relationship to the Employee:
  - 02 Spouse/Civil Union
  - 03 Child up to age 26
  - 06 Disabled (verification required)
  - 07 Ex-spouse
  - DP Domestic Partner
  - SE Spousal Equivalent

When this application is complete: Please sign the enrollment form and provide it to your employer. Your employer will need to sign this form and will forward this application to Harvard Pilgrim Health Care for processing. If you need additional assistance completing this form or selecting a PCP, please call a member services coordinator at 1-888-333-4742.

Coverage underwritten or administered by Harvard Pilgrim Health Care. Harvard Pilgrim Health Care includes Harvard Pilgrim Health Care, Harvard Pilgrim Health Care of Connecticut, Harvard Pilgrim Health Care of New England and HPHC Insurance Company.

Thank you for choosing a Blue Cross Blue Shield plan.

Please take a few minutes to help us set up your membership by filling out the attached enrollment form.

Before You Begin

Please read the instructions below carefully.

For members of HMO Blue,® Network Blue,® Blue Choice,® HMO Blue New England,℠ or Blue Choice New England℠: You are required to choose a primary care physician (PCP) when you enroll. Please choose a PCP from your plan's provider directory. Be sure to read "PCP ID #" in Section 2. List your PCP choice on your enrollment form. The PCP ID number can also be found by visiting **www.bluecrossma.com** and selecting **Find a Doctor**.

For Access Blue℠ Members: Although you are not required to choose a PCP, we recommend you choose one by following the instructions in Section 2 on the back of this page.

Important: Are you covered by Medicare or other insurance? We need to know if you or any family member listed have Medicare and/or other insurance. Please be sure to circle either Y (for yes) or N (for no) in the correct box. This information will help us accurately coordinate your benefits. Please follow the instructions in Section 2 and 3.

Print two copies, one for your records and one for your employer to sign and mail to Blue Cross Blue Shield of Massachusetts. In order to complete your enrollment request, your employer is required to sign the application.

Special Instructions for Student Coverage: If you are seeking coverage for a full-time student dependent over age 19, you may need to fill out a Student Certificate form. Check with your employer to see if this coverage is available.

Blue Cross Blue Shield of Massachusetts
P.O. Box 986001
Boston, MA 02298

Instructions

Section 1 To Be Filed Out By Your Employer

Your employer will fill out this section.

Type of Transaction - Check the box(es) that apply.

Subscriber Cancellation Codes. If the subscriber will not be continuing any Blue Cross Blue Shield coverage, carefully select one of the following and indicate the three-digit code on the form.

Code #	Situation
041	• Changing to other health plan • Voluntary termination • COBRA cancellation (under 18 months or nonpayment)
042	• Over 65, changing to Group Medex® plan. (Requires Medicare A and B) • Over 65, changing to direct-pay Medex plan. (Requires Medicare A and B) • Over 65, changing to Medicare supplement other than Medex plans.
043	• Medicare (age =< 65)

Code #	Situation
061	• Left employment • COBRA ending
063	• Transfer
064	• Cancellation as of original effective date
070	• Deceased
071	• Moved out of state (out of HMO service area)
076	• Military service

Note: If your subscribers are adding or dropping one benefit only (medical/dental), please indicate "add medical," "add dental," "cancel medical," or "cancel dental" in the "Remarks" section.

If your new hires are subject to a probationary period, please indicate the time frame in the "Remarks" section, as well as the qualifying events for new enrollees.

If a subscriber is being moved from an active group to a retiree group (within the same account), this is a transfer and not a termination. Please include the Medical or Dental Group # transferring to.

Cancellation date will be the first day of no coverage.

Qualifying Events - Remarks:

To assist in the enrollment process, please use check boxes or write in applicable information in the "Remarks" section of the form.

- Open Enrollment - Check this box for open enrollment.
- New Hire - Check this box for new hires to the company.
- COBRA - Check this box if person is continuing coverage under COBRA.
- Add Spouse - Check this box if spouse is being added. Ensure date of marriage is within approved retroactive period.
- Add Dependent - Check this box if adding any dependent.
- Loss of Coverage - Check this box if person lost coverage through spouse or parent. Please include HIPAA Continuous of Coverage Letter from prior company/insurer. If you have questions contact your account service representative.
- Other - Check this box if change to family requires additional explanation. Please write in the reason for change (e.g., Court Order, Adoption, New Dependent Law under HCR, Legal Guardianship, etc.). Include supporting documentation. If you have questions contact your account service representative.

Section 2 Tell Us About Yourself (Member 1)

Please fill in all information that applies to you. (REQUIRED)*

PCP ID# - If your health plan requires you to choose a primary care physician (PCP), please fill in this section. Write the PCP ID number (***not*** the telephone number) of the doctor you have chosen to coordinate your health care. You'll find the doctor's PCP ID number in the provider directory for your health plan. If you need help choosing a PCP, please call our Physician Selection Service at **1-800-821-1388**. A representative will be happy to help you select a doctor. PCP ID number can be found at **www.bluecrossma.com**, select **Find a Doctor**.

Other Insurance - Do you have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*)) in the correct box. If you have other insurance, please write the name of the other insurance company and its location (city and state).

To Add or Delete a Member - Are you adding or deleting a member under your existing membership? If yes, please fill in the areas in Sections 1 and 2. You may need help from your employer to fill in Section 1. Then, give us the details about the members you're adding or deleting in Section 3 and/or Section 4.

Section 3 Tell Us About Your Spouse (Member 2)

If you choose a **Family** membership, please fill in this section if you want Member 2 to be covered. (REQUIRED)* (Note: Member 2 cannot be covered under an **Individual** membership.)

Other Insurance - Does your spouse have other health insurance or Medicare? Please be sure to circle either **Y** (for *yes*) or **N** (for *no*) in the correct box. If your spouse has other insurance, please write the name of the other insurance company and its location (city and state).

Section 4 Tell Us About Your Eligible Dependents (Members 3, 4, and 5)

If you choose a **Family** membership, please fill in this section for all children or other eligible dependents you want to be covered. (REQUIRED)* (Note: Dependents cannot be covered under an **Individual** membership.)

If you have more than three dependents to be covered, please use additional Enrollment Forms as needed. Please indicate on the form that additional forms have been used and write in the total number of dependents you want to be enrolled.

Section 5 Select Personal Savings Account

Your employer may have chosen to offer a personal savings account alongside your medical offering. Please consult your open enrollment materials and/or your HR department to determine if this applies to you.

For each option:

Start Date: Your start date will be considered established for tax purposes as of the start date of your medical plan, provided that you have signed, dated and submitted the completed application for these accounts on or before that date.

End Date: Your end date is the date you choose to stop deposits into the selected financial account. If you have any questions please see your employer.

Note: If you are transferring from one medical/dental plan to another medical/dental plan, please provide notification that you will be continuing your personal savings account by completing Section 5 of the Enrollment and Change form.

Section 6 Signatures (Employer & Employee)

Employee: Please sign & date the application and return it to your employer. Employer: Please sign & date the application and return to Blue Cross Blue Shield of Massachusetts.

(REQUIRED)* Under the Affordable Care Act, we are required to collect the Social Security number for you and any dependent enrolling in your plan.

lease Read the Instructions
Before Filling Out This Form.

Please PRINT CLEARLY using blue or black ink to avoid coverage delay or type in information

MASSACHUSETTS

Blue Cross Blue Shield of Massachusetts is an Independent Licence of the Blue Cross and Blue Shield Association.

Enrollment and Change Form.

Please mail to: P.O. Box 986001
Boston, MA 02298 or fax to 1-617-246-7531

1. To Be Filled Out by Your Employer

Company Name	Current Medical Group #:	Medical Group #, Transferring To
Current BCBS ID #, If any	Requested Effective Date MM DD YYYY	Date of Hire MM DD YYYY
Current Dental Group #:	Dental Group #, Transferring To	

Type of Transaction
❒ ADD
❒ CHANGE
❒ TRANSFER
❒ CANCEL

(If canceling, please see instructions for three digit termination code.) ☐☐☐

Remarks: (i.e., qualifying event for a new add, change to family or other instruction)

❒ Open Enrollment
❒ New Hire
❒ COBRA

Change to Family
❒ Add Spouse
❒ Add Dependent

❒ Loss of Coverage
(HIPAA Continuation of Coverage Letter Required)
❒ Other _____

2. Tell Us About Yourself (Member 1)

What products are you selecting?
❒ HMO Blue
❒ Network Blue
❒ Blue Choice
❒ Saver Blue
❒ Dental Blue
❒ Access Blue
❒ PPO
❒ HMO Blue New England
❒ Blue Choice New England
❒ Group Medex or Managed Blue for Seniors
❒ Blue Medicare Rx (Part D)

Kind of Membership (Medical)
❒ Individual
❒ Family

Kind of Membership (Dental)
❒ Individual
❒ Family

Your First Name	M.I.	Last Name	Sex	Date of Birth
Street Address / P.O. Box #:	Apt. #:	City / Town	State	Zip Code

Social Security # (REQUIRED)*:	Telephone #: (area code) ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	City / State
PCP ID #: (see instructions)	Name of PCP	City / State	Is this your current PCP? Mark X, if yes. ☐	

Are you covered by Medicare? Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #: ❒ 65+ ❒ Disabled ❒ ESRD	Actively Working? Y ❒ / N ❒ If Retired, Date:

3. Tell Us About (Member 2)

Please Check One: ❒ Spouse ❒ Domestic Partner ❒ Divorced Spouse (court ordered)

Member 2's First Name	M.I.	Last Name	Sex	Date of Birth
Street Address / P.O. Box #:	Apt. #:	City / Town	State	Zip Code

Social Security # (REQUIRED)*:	Telephone #: (area code) ( )	Other Insurance?[1] Y ❒ / N ❒	Other Insurance Company Name	City / State
PCP ID #: (see instructions)	Name of PCP	City / State	Is this your current PCP? Mark X, if yes. ☐	

Is Member 2 covered by Medicare?[1] Y ❒ / N ❒	Part A Effective Date MM DD YYYY	Part B Effective Date MM DD YYYY	Part D Effective Date MM DD YYYY	Medicare #: ❒ 65+ ❒ Disabled ❒ ESRD	Actively Working? Y ❒ / N ❒ If Retired, Date:

1. *If you have not indicated Yes or No regarding your Medicare or other insurance status, you may receive a follow-up questionnaire.*

4. Tell Us About Your Eligible Dependents (Member 3, 4, and 5)

Dependent's First Name 3.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒
Social Security # (REQUIRED)*:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. ☐
Dependent's First Name 4.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒
Social Security # (REQUIRED)*:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. ☐
Dependent's First Name 5.)	M.I.	Last Name	Sex	Full-time student and aged 19 or older ❒ Disabled and aged 26 or older ❒
Social Security # (REQUIRED)*:	Date of Birth	PCP ID #: (see instructions)	Name of PCP	Is this your current PCP? Mark X, if yes. ☐

Please check if you are using separate forms for additional dependent children ❒ Total # of Dependents: _____

5. Select Personal Savings Account

☐ HSA: Health Savings Account	Start Date:	End Date:	FSA GOAL AMOUNTS: (Please see instructions for limits.)
☐ FSA – Health: Health Flexible Spending Account	Start Date:	End Date:	Health $:
☐ FSA – Dep.: Dependent Care Reimbursement Account	Start Date:	End Date:	Dependent Care $:

6. Signature (Employer & Employee)

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Employee's Signature _____ Date _____ Employer's Signature _____ Date _____

Important Notice for Benefit Eligible Employees

There is a <u>30 day window</u> from the qualifying event, to notify the Health Insurance Companies of any changes to your health insurance. If the insurance companies do not receive the appropriate documentation within the 30 day window the employee and/or dependent(s) cannot be enrolled until the next July 1st (through the annual Open Enrollment period) or until a subsequent qualifying event.

Please take the time to come in and submit the following changes as soon as they happen:

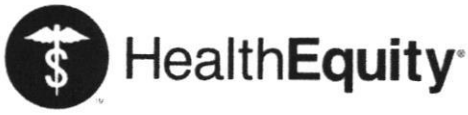
1. New Hires
2. Change of Employment Status - under/over 20 hours per week
3. Birth/Adoption - Birth Certificate or Adoption Certificate
4. Marriage - Marriage Certificate
5. Divorce, Legal Separation or Remarriage of an Employee or his/her Spouse
6. Involuntary Loss of Coverage - see HIPAA and CHIPRA Special Enrollment Notices
7. Change in Residence – this can affect your health plan, receiving your1099 HC and mailings
8. Name Change
9. Phone Number Change
10. Adult Children turning Age 26 - see attached notice from West Suburban Health Group
    - Please Note: Disabled Children over 26 will need appropriate paperwork completed and approved by the insurance company each year to continue to be insured.
11. Turing age 65
12. Entitlement to Medicare for employee, spouse or child

Not updating your personal information could also result in costly consequences of claims being denied or not being paid in a timely manner.

Thank you in advance for your cooperation.

Donna Bouchard
Benefits Administrator
508-841-8359 or email Benefits@shrewsburyma.gov

Employee HSA payroll deduction form



Return completed forms to:

Company name: _____

Attn: _____

Fax: _____

Email address: _____

Annual employer contribution information

Self-only	Family	Other (optional)

For mid-year enrollees, contact your HR department for your pro-rated employer election amount.

Notes

HSA contribution limits and contribution calculator

2018 annual HSA contributions		
Coverage type	Total annual contribution*	Per month
Self-only	$3,450	$287.50
Family	$6,900	$575.00

*Catch-up contribution (age 55+): additional $1,000/year

2019 annual HSA contributions		
Coverage type	Total annual contribution*	Per month
Self-only	$3,500	$291.67
Family	$7,000	$583.33

*Catch-up contribution (age 55+): additional $1,000/year

Total annual contribution	- (MINUS)	Total annual employer contribution	=	Total eligible amount
				0

Total eligible amount	/ (DIVIDED)	Enter number of pay periods remaining in the year from form submittal date	=	Per-pay period max withholding
0		1		0

Eligibility and contribution limits to your health savings account (HSA) are determined by the effective date of your high-deductible health plan (HDHP). If you're covered as of December 1, you're considered an eligible individual for the entire year and you're not required to pro-rate your contributions. If you cease to be an eligible individual during the next calendar year, any funding over the prorated amount is considered an excess contribution and subject to a penalty and income tax. For further information or to review eligibility, please contact HealthEquity Member Services at 866.346.5800.

Employee information and authorization

Employee name	Last 4 of SSN or employee ID

Please withhold $ _____ from my (weekly/bi-weekly/monthly) payroll and apply the funds to my HealthEquity HSA.

Signature	Date

Town of Shrewsbury
Basic & Optional Life Insurance FAQ

How much life insurance does the Town offer?
The Town of Shrewsbury offers employees the opportunity to purchase $7,000 of basic life insurance, and will pay 50% of the premium. Your cost for the basic coverage is $4.24 per month.

How much more insurance can I buy?
If you enroll in basic life insurance you may also purchase optional life insurance in increments of $10,000 to the maximum of $500,000 (not to exceed 7 times your base pay), with a guaranteed issue amount of $150,000. Over the age of 70 the guaranteed issue is $10,000 without additional health questions.

What is the cost of optional life insurance?
See the back of this sheet for rates. This cost is based on your age at the time the policy is issued; therefore, your premium will **not** increase as you get older.

Can I purchase life insurance for my spouse or children?
Yes, however; you must have optional life coverage in order to insure your spouse and/or children. For your spouse you can purchase optional life insurance in increments of $10,000 to the maximum of $150,000 (not to exceed 100% of your optional life coverage), with a guaranteed issue amount of $30,000. For your unmarried dependent children to age 19 (or up to 25 if a full-time student) you can purchase $10,000 of optional life insurance.

Can I wait until I'm older to sign up for this coverage?
Each employee is offered one opportunity to sign up for this coverage without having to submit medical evidence of insurability. This means that in your first 30 days of employment you are guaranteed up to $150,000 of insurance without having to answer any medical questions. When you get older you may not be medically capable of qualifying.

How can I get more info?
For more information please contact Donna Bouchard at (508) 841-8359.

BOSTON MUTUAL LIFE INSURANCE COMPANY 1-800-669-2668 x700

120 Royall Street • Canton, MA 02021

PLEASE PRINT OR TYPE ***Please refer to your Administration Kit for enrollment and mailing instructions***

GROUP BENEFITS ENROLLMENT FORM

EMPLOYEE / FAMILY INFORMATION

Employer/Policyholder _____ Dept. ID _____

Employee Name *(Last, First, Middle)* _____ Social Security Number _____

Home Address *(Street, City, State, Zip)* _____ ( ) Telephone # _____

Gender *(M/F)* _____ Occupation or Job Title _____ Date of Birth _____ Age _____ PAYROLL TYPE: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Annual Earnings: $ _____

Average Hours Worked _____ Date of Hire _____ or Date of Full Time Employment if different _____ Effective Date _____ State _____ Class _____

Spouse *(Last, First, Middle)* _____ Gender *(M/F)* _____ Date of Birth _____ Age _____ No. of Dependents _____

LIFE

You Must Have Basic Coverage to Elect Voluntary Coverage

BASIC:

Group # _____ **Div.** _____

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$ _____

You Must Have Voluntary Coverage to Elect Dependent Coverage

VOLUNTARY:

Group # _____ **Div.** _____

	YES	NO	Insurance Amount
LIFE & AD&D	❑	❑	$ _____
SPOUSE	❑	❑	$ _____

DEPENDENT LIFE:

CHILD(REN)	❑	❑	$ _____

BENEFICIARY

Name of Your Beneficiary(ies) for Life and/or AD&D Benefits: *(Total Percentage of Benefit must equal 100%)* **List Additional Beneficiaries on separate sheet**

Primary Beneficiary(ies):	Residential Address	Date of Birth	Social Security #	Tel. #	Relationship	% of Benefit
Contingent Beneficiary(ies):						

If you designate more than one beneficiary, please be sure the total percentages of benefit equals 100%. If you do not designate a percentage payable for each beneficiary, the total proceeds payable will be divided equally among each beneficiary. If an insured dependent dies, we will pay the proceeds to you.

ACCEPTANCE OF INSURANCE - *Employee Signature Required*

SIGNATURE

I apply for the insurance for which I am now eligible *(or for which I may become eligible)* under the provisions of the Group Policy or Group Policies issued to my employer by the Boston Mutual Life Insurance Company and authorize deductions, if any, from my earnings of the required premium contribution toward the cost of the insurance. *I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.* I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ **Date** _____

REFUSAL OF INSURANCE

Employee Name _____ *(Last, First, Middle)* Employee/Policyholder _____ Group No. _____

I hereby certify that I have been given an opportunity to participate in the Group Insurance Plan offered by my Employer *(or the Association with whom I am affiliated)* and insured by Boston Mutual Life Insurance Company and that I have declined to do so with respect to:

❑ Basic Life & AD&D ❑ Voluntary Life & AD&D ❑ Dependent Life

I further understand that if I desire to participate in the Plan at a later date with respect to the coverage checked, I must furnish, at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____

Group Basic Life and Accidental Death & Dismemberment Benefit Summary for Eligible Employees of Town of Shrewsbury

The following information is a summary of benefits; this summary is not your Certificate nor does it constitute coverage for claim. Any discrepancies between this summary and the group policy will be resolved by the language issued in the master policy. Please contact your benefits administrator for policy provisions.

Eligibility
All Eligible Active Employees working a minimum of **20** hours per week are eligible. *If you are not actively at work on the effective date then insurance will not become effective until you return to active employment.*

Employee Basic Life and AD&D Benefit

- Flat $7,000.
- Upon retirement, Basic Life and AD&D coverage continues at $7,000.

Cost of Coverage
You, the employee, currently contribute to the cost of the Basic Group Life and AD&D coverage. Please consult your Benefits Administrator for specific contribution percentage.

Portability
If you leave your employment prior to age **60**, the coverage is "portable" for you. You may elect to exercise this option in accordance with the provisions as defined by the policy. The coverage would not include Waiver of Premium.

Conversion
Employees have 31 days from the date of termination to convert their Basic Life Insurance to an individual permanent life policy without evidence of insurability. The premium will be based on Boston Mutual's usual rate for the insured's age on the date of conversion. Coverage will not include Waiver of Premium.

Waiver of Premium
If you become totally disabled prior to age 60 and remain totally disabled for the period stated in the policy, Boston Mutual will continue your insurance without any further payment of premiums subject to the provisions of the contract.

Accelerated Death Benefit
This provision enables an employee diagnosed and certified by a Doctor with a terminal illness, resulting in a life expectancy of twelve months or less, to receive a portion of the life insurance benefit prior to death. The remaining benefit will be paid to the beneficiary.

Education Benefit
We will pay a percentage of an employee's life insurance benefit to a maximum of $2,500 per year, for up to four years of education, to each qualifying dependent if the employee's death is the result of an accident while covered under Group AD&D.

Seat Belt Benefit
We will pay an additional 50% of the AD&D benefit, not to exceed $10,000, in the event of an insured's death as a result of an automobile accident while wearing a properly secured seat belt.

Repatriation of Remains Benefit
If an employee dies as a result of an Accident while insured for AD&D and the death occurs outside a 100 mile radius from his or her primary residence, we will pay for Covered Expenses reasonably incurred to return his or her body to their primary residence up to $5,000.

Exclusions
Under the AD&D coverage, benefits are not payable for losses caused by or contributed to by: self-inflicted injuries, suicide or attempted suicide, riot or war, diseases, ptomaine or bacterial infection, drug and/or alcohol abuse, commission of an assault or felony by an employee, accident while serving on active duty, travel or flight in any aircraft or device which can fly above the earth's surface (does not apply to commercial flights) or injury which occurred before the Employee was insured by this policy. All exclusion details are stated in the master policy and certificate which may be reviewed through your benefit administrator.

Also available to you...

Bereavement Counseling*
This service is provided to all beneficiaries who experience the loss of a loved one. Beneficiaries have access to a toll-free counseling service supported by professional counselors experienced with the human emotions associated with the death of a loved one.

**Services provided by Health Management Systems of America – a nationally recognized leader in the field of Mental and Behavioral Health Care Services. These services are currently available but are not part of your Boston Mutual policy/contract.*